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# In the Supreme Court of the United States

OCTOBER TERM, 1986

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

*v.*

STANLEY CUBANSKI, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES, ET AL.

**PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT**

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## QUESTIONS PRESENTED

1. Whether language in an internal agency manual prepared for use by field employees is a "legislative regulation" that binds the Secretary of Health and Human Services, even though it was never subjected to notice-and-comment rulemaking or published in the Federal Register, and even though it is contradicted by a regulation duly promulgated by the Secretary pursuant to the Administrative Procedure Act.

2. Whether Section 2373(c) of the Deficit Reduction Act of 1984 prohibits the Secretary of Health and Human Services from disapproving proposed amendments to state Medicaid plans that conflict with statutory limitations on federal financial participation in the Medicaid program.

## PARTIES TO THE PROCEEDING

In addition to those named in the caption, the parties are: Donald A. Barrier, Alan Bierman, Lola Bierman, James Jones, and Ronald Kwiek, all of whom intervened in the administrative proceedings and in the court of appeals.

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**PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT**

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The Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (App., *infra,* 1a-19a) is reported at 781 F.2d 1421. The opinion dissenting from the denial of rehearing en banc (App., *infra,* 23a-35a) is reported at 794 F.2d 540. The opinion of the Administrator of the Heath Care Financing Administration (App., *infra,* 38a-45a) is unreported.

## JURISDICTION

The judgment of the court of appeals was entered on February 7, 1986 (App., *infra,* 21a). An order amending the panel opinion was entered on March 6, 1986 (App., *infra,* 20a). A petition for rehearing was denied on July 14,

1986 (App., *infra,* 22a). An opinion dissenting from the denial of rehearing en banc was filed on July 18, 1986 (App., *infra,* 23a-35a). On October 3, 1986, Justice O'Connor extended the time for filing a petition for a writ of certiorari to and including November 26, 1986. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant portions of Sections 1902(a) and 1903(f) of the Social Security Act, 42 U.S.C. 1396a(a) and 1396b(f), of Section 2373(c) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, of 42 C.F.R. 435.811 and 435.1007, and of Section 14005.12 of the California Welfare and Institutions Code, are set out at App., *infra* 46a-49a.

## STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae,* 448 U.S. 297, 301 (1980); see *Atkins* v. *Rivera,* No. 86-632 (June 23, 1986), slip op. 2. Medicaid is a cooperative federal-state program employing both state and federal funds. See 42 U.S.C. 1396b. The decision whether to participate in Medicaid is left to the discretion of each state. Once a state elects to participate, it must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services. See 42 U.S.C. (& Supp. II) 1396a; *Atkins* v. *Rivera,* slip op. 2; *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 37 (1981). Upon obtaining the Secretary's approval of its Medicaid plan, a state is entitled to federal financial assistance for providing medical care to individuals who qualify under that plan. See 42 U.S.C. (& Supp. II) 1316(a), 1396, 1396a(b), 1396b(a).

Individuals covered by certain cash assistance programs—the Supplemental Security Income (SSI) Program, 42 U.S.C. 1381 *et seq.*, and the Aid to Families With Dependent Children (AFDC) Program, 42 U.S.C. 602 *et seq.*—automatically qualify for Medicaid. Thus, states that choose to participate in Medicaid are required to provide benefits to these persons, termed the "categorically needy." See 42 U.S.C. 1396a(a)(10)(A)(i); 42 C.F.R. 435.4, 433.110(a), 435.120(a); *Atkins* v. *Rivera,* slip op. 2; *Gray Panthers,* 453 U.S. at 37-39. In addition, and at its option, a participating state may provide Medicaid benefits to other "less needy" individuals. See H.R. Rep. 213, 89th Cong., 1st Sess. 66 (1965). In general, these are "medically needy" people who would qualify for SSI or AFDC except that their income and resources exceed the levels set for those categorical assistance programs. See *Atkins* v. *Rivera,* slip op. 3; *Schweiker* v. *Hogan,* 457 U.S. 569, 572-573 (1982). The "medically needy" qualify for Medicaid only if they incur medical expenses that reduce their income to the Medicaid eligibility income standard. See 42 U.S.C. 1396a(a)(17); 42 C.F.R. 435.831(c).

At the beginning of the Medicaid program, no limit was placed on the amount of federal reimbursement to the states for optional coverage given the "medically needy." In 1967, however, Congress determined that a limit on federal participation was desirable to guard against improvident Medicaid spending by the states. See *Hogan,* 457 U.S. at 573, 576. Accordingly, Congress enacted legislation to ensure that "federal sharing * * * not be available for families whose income exceeds 133⅓ percent of the highest amount ordinarily paid to a family of the same size * * * in the form of money payments under the AFDC program." H.R. Rep. 544, 90th Cong., 1st Sess. 117, 119 (1967). To effect that congressional purpose, Section 1903(f)(1)(B)(i) of the Social Security Act, 42 U.S.C.

1396b(f)(1)(B)(i), provides that federal financial participation is limited as follows:

> the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the [AFDC] plan of the [relevant] State * * *.

The Secretary issued regulations in 1971 pursuant to this directive. 36 Fed. Reg. 3871-3872. Those regulations, now codified at 42 C.F.R. 435.1007, reiterate the statutory requirement that Medicaid benefits bear a fixed mathematical relationship to the AFDC benefits that would be paid to "a family of the same size." The regulations provide that, for couples and families of two or more, federal financial participation is available only when the state's Medicaid eligibility level does not exceed "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources." 42 C.F.R. 435.1007(a)(1). See also 42 C.F.R. 435.811(c).[1]

2. Respondent Cubanski is the Director of the California Department of Health Services. In September 1983, California proposed to amend its Medicaid plan to provide more generous benefits. Specifically, California proposed to revise upward its "medically needy income level"

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[1] The regulations promulgated in 1971 were initially codified at 45 C.F.R. 248.21(b)(2) and (3) (1972 ed.). They were recodified in 1974 at 45 C.F.R. 248.4(b)(4) (1974) and again in 1978 at 42 C.F.R. 448.4(b)(4). In September 1978, the regulations were amended to their present form and recodified at 42 C.F.R. 435.1007. The language at issue in this case ("family of the same size") has not undergone substantive change since the initial regulations were issued in 1971.

(MNIL), which is the maximum amount of income that a medically needy individual or family may keep for nonmedical needs and still be eligible for Medicaid.[2] Under the State's proposed amendment, the monthly MNIL for a family consisting of *two* adults would be 133⅓ percent of "the highest amount that would ordinarily be paid to a family of *three* persons without income or resources under [the State's AFDC program]." Cal. Welf. & Inst. Code § 14005.12(c) (West Supp. 1986) (emphasis added).

In December 1983, the Health Care Financing Administration (HCFA), a subdivision of HHS, notified the State that its proposal was rejected because it did not comply with the statutory and regulatory requirement that Medicaid payments not exceed 133⅓ percent of the maximum AFDC payment "to a family of the same size" (42 U.S.C. 1396b(f)(1)(B)(i); 42 C.F.R. 435.1007(a)). On administrative appeal, that decision was ultimately upheld by the HFCA Administrator (App., *infra*, 38a-45a).

The State's principal argument throughout the administrative process was that its proposed amendment was supported by language that appeared in a HCFA regional office manual that was issued on June 30, 1979. In contrast to the regulation promulgated by the Secretary in

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[2] The effects of a change in the MNIL may be illustrated by a simplified example. Assume a "medically needy" individual with monthly "countable" income of $300 and monthly medical expenses of $150. If the state's MNIL is $200, that individual may retain $200 for nonmedical needs; Medicaid will pay for $50 of his medical expenses and he will be responsible for the $100 balance. Now assume that the state raises its MNIL to $250. That same individual would then keep $250 for nonmedical needs; Medicaid would cover $100 of his medical bills, and he would be responsible for only $50 per month. As this illustration shows, the higher the MNIL, the greater the proportion of medical expenses covered by Medicaid. Program costs further escalate with a higher MNIL because greater numbers of people qualify for benefits.

1971, as amended in 1978, which required that a state's Medicaid MNIL be no more than 133⅓ percent of the state's maximum AFDC payment for a family "of the same size," the field manual said (§ 2572D) that "the States may set a separate medically needy income level for two adults which would be established between 133-⅓% of the AFDC payment level for one person and 133-⅓% of the AFDC payment level for a family of three persons." The manual also said that states "should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults" (*ibid.*). These sentences were deleted from a superseding edition of the manual issued in July 1980.

The HCFA Administrator rejected the State's contention. She concluded that "the statute provides for a single MNIL for a family of two" and that this limit is 133⅓ percent of the maximum payment ordinarily made under the State's AFDC plan "to a family of the same size without income and resources" (App., *infra*, 42a). The Administrator concluded that the Secretary's regulation, which likewise speaks of AFDC payments "to a family of the same size" (42 C.F.R. 435.1007), was "absolutely clear regarding a family of two" (App., *infra*, 42a). The Administrator found the language in the HCFA field manual to be "patently contrary to the statute and * * *, therefore, invalid from its origination," since "the Secretary is bound to follow the direction of Congress" (App., *infra*, 44a).[3]

3. On petition for review, the court of appeals reversed the agency's determination (App., *infra*, 1a-19a). The court concluded that the statutory directive limiting

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[3] The Administrator also rejected the State's alternative argument that Section 2373(c) of the Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369, 98 Stat. 1112, prohibited the Secretary from disapproving the proposed amendment of the state plan.

federal financial participation to 133⅓% of the highest AFDC payment "to a family of the same size" was tempered by language requiring that this limit be determined "in accordance with standards prescribed by the Secretary." App., *infra,* 7a, citing 42 U.S.C. 1396b(f)(1)(B)(i). In the court's view, the 1979 office manual prescribed just such a "standard," and a state was therefore permitted to set its MNIL for two adults as high as "133⅓ percent of the AFDC payment level for a family of three persons." The manual, the court concluded, set forth "a proper legislative rule" because it is a "rule 'issued by an agency pursuant to statutory authority and . . . implements the statute' " (App., *infra,* 13a, quoting *Batterton* v. *Francis,* 432 U.S. 416, 425 n.9 (1977)).

Citing this Court's decision in *Schweiker* v. *Hansen,* 450 U.S. 785 (1981), the court of appeals acknowledged that "agency office manuals generally do not prescribe legislative rules with binding effect" (App., *infra,* 11a). But the court held that this case represented "an exception" to that principle, asserting that the office manual involved here was "not a field-level instructional guide" because it was supposedly "directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans" (*ibid.*). The court said that the 1979 version of the HCFA regional manual "establishe[d] the right of states to increase their adult couple MNIL" and "establishe[d] a new MNIL maximum * * * and thereby 'effect[s] a change in existing law or policy' " (*ibid.,* quoting *Powderly* v. *Schweiker,* 704 F.2d 1092, 1098 (9th Cir. 1983)).

Although the language in the field manual had never been subject to notice-and-comment rulemaking, and although it had not been published in the Federal Register or the Code of Federal Regulations, the court of appeals held that the manual had been properly promulgated as a "legislative regulation." The court noted (App., *infra,* 13a)

that the notice-and-comment procedures of the Administrative Procedure Act (APA) are generally inapplicable to matters relating to public benefits (5 U.S.C. 553(a)(2)). Although the Secretary by formal notice (36 Fed. Reg. 2532 (1971)) has voluntarily imposed the full panoply of APA procedural requirements upon HHS in such matters, the court said that these were not " 'procedural requirements imposed by Congress' " and hence concluded that the absence of notice-and-comment proceedings did not deny the manual the force of law (App., *infra,* 14a, quoting *Chrysler Corp.* v. *Brown,* 441 U.S. 281, 303 (1979)). With respect to the requirement of the Freedom of Information Act (FOIA) that agency regulations be published in the Federal Register (5 U.S.C. 552(a)(1)(D)), the court concluded that the FOIA requirement attaches only where nonpublication would adversely affect a member of the public, a situation that the court found was not present here (App., *infra,* 15a). The court therefore held that the manual was a lawfully promulgated regulation, exempt from the notice-and-comment procedures of the APA and the FOIA. And the Court held as an alternative ground of decision that "the DEFRA moratorium" in any event barred the Secretary from disapproving the proposed amendment to California's Medicaid plan (App., *infra,* 16a-18a).

4. The Secretary's suggestion for rehearing en banc was denied, with Judges Kozinski, Sneed, Hall and Noonan dissenting (App., *infra,* 22a-35a). In the dissenters' view, "[t]he panel err[ed] in almost every respect" (*id.* at 26a). The dissent pointed out that the HCFA's regional office manual was "not a body of regulations," but rather was "an *office manual,* an internal directive from the agency's headquarters to its field offices" (App., *infra,* 26a (emphasis in original)). The manual's "foreward," the dissent observed, stated that it was "for the use of regional office employees only," that it was "not intended to stand

alone," and that it "should not be cited when addressing contractors, State agencies, providers, etc." (*id.* at 26a-27a). Thus, even if the manual were the only statement on the subject emanating from the government, the dissent concluded that the manual would not, under *Schweiker* v. *Hansen, supra,* constitute a "legislative regulation" with the force and effect of law.

The dissent went on to argue that this conclusion followed a fortiori here, since the Secretary had in fact promulgated valid regulations that "plainly conflict" with the manual section (App., *infra,* 29a). Instead of deferring to these regulations, which explicitly link Medicaid entitlement to AFDC families "of the same size," the panel "effectively read[] the regulations out of existence without any explanation or admission of the fact" (*id.* at 30a). By subordinating formally promulgated regulations to an internal agency publication, the panel opinion, in the dissent's view, "tears asunder [the] tenets of administrative law" (*id.* at 31a) and "create[s] uncertainty where stability is vital" (*id.* at 32a). Judge Kozinski expressed concern that the panel opinion "will cause no end of headaches for agency officials who will now have to guess which of their informal, unsigned internal guidelines will be found 'exceptional' enough to outrank regulations" (*ibid.*). And he pointed out that, even if the manual could be thought to be a "regulation," it would be invalid "because it violates the plain language of the statute" (*id.* at 30a).

The dissent also took issue with the panel's alternative holding based on the DEFRA moratorium. Relying in part on this Court's decision in *Atkins* v. *Rivera, supra,* the dissent pointed out that the DEFRA moratorium "has nothing at all to do with this case" since it was intended to restrict the Secretary's authority under a portion of the statute not involved here (App., *infra,* 34a). In Judge Kozinski's words, "[t]he two provisions have about as

much in common as apples and pineapples: They sound vaguely similar but they grow on entirely different statutory trees."

## REASONS FOR GRANTING THE PETITION

The decision below elevates to the status of a binding regulation language in an internal agency manual that was never published in the Federal Register or the Code of Federal Regulations, that was never intended as an official agency pronouncement, and that is flatly inconsistent both with a validly promulgated regulation of the Department of Health and Human Services and with the plain language of the statute. The court of appeals' decision reaching this odd result directly conflicts with decisions of this Court and with settled principles of administrative law. See *Schweiker* v. *Hansen*, 450 U.S. 785 (1981); *Morton* v. *Ruiz*, 415 U.S. 199 (1974). If it is permitted to stand, the decision below will generate enormous confusion as government officials—and those subject to regulation—are left to guess which statutes and regulations will be subordinated to the views expressed in documents such as the manual at issue here.

The court of appeals' alternative holding is equally devoid of merit. By expanding the DEFRA moratorium far beyond Congress's intent, the decision below prevents the Secretary from ensuring that proposed amendments to state plans are consistent with all requirements of the Social Security Act. It substantially undermines federal fiscal control over the Medicaid program. The Department of Health and Human Services estimates that the particular plan amendment proposed by California in this case would increase federal Medicaid expenditures by $50 million annually.

1. We start with the language of the statute. Congress provided that a state's entitlement to federal fiscal participation in Medicaid is limited by reference to the state's

level of AFDC benefits paid "to a family of the same size" (42 U.S.C. 1396b(f)(1)(B)(i)). The House Report makes clear the intent that "[f]ederal sharing will not be available for families whose income exceeds 133⅓ percent of the highest amount ordinarily paid to a family of the same size * * * in the form of money payments under the AFDC program." See H.R. Rep. 544, 90th Cong., 1st Sess. 119 (1967); *Schweiker* v. *Hogan*, 457 U.S. at 577.

The Secretary has interpreted this provision in a way that is consistent with the plain language and evident purpose of the statute. To implement the Act's limitation of federal participation in Medicaid to 133⅓% of the AFDC benefit paid to a family of the "same size," the Secretary has prescribed by regulation that federal financial participation is available only when it does not exceed, for couples and families of two or more, "133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources" (42 C.F.R. 435.1007 (a)(1)). This regulation and its predecessors have been in force for more than 15 years. See 43 Fed. Reg. 45217 (1978); 36 Fed. Reg. 3871 (1971); note 1, *supra*. As this Court recently explained, regulations of this type are entitled to "legislative effect" (*Atkins* v. *Rivera*, slip op. 7):

> Because the Secretary's regulation is "supported by the plain language of the statute and is adopted pursuant to the explicit grant of rulemaking authority * * *, it is entitled to more than mere deference or weight." *Gray Panthers*, 453 U.S. at 44, quoting *Batterton* v. *Francis*, 432 U.S. at 426. Indeed, it is entitled to "legislative effect," *id.* at 425, and is controlling "unless [it] is arbitrary, capricious, or manifestly contrary to the statute," *Chevron U.S.A., Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984).

2. In contrast to the statute and regulation, which both refer to families of "the same size," California's proposed plan amendment would calculate Medicaid benefits for a family of *two* by reference to the highest AFDC payments to a family of *three*. Recognizing that a family of three is not the "same size" as a family of two, the Secretary properly disapproved California's proposal. In overturning the Secretary's determination, the court of appeals relied on the Act's delegation of authority to the Secretary to prescribe standards for determining what amount is "equivalent to 133⅓ percent of the highest amount which would normally be paid to [an AFDC] family of the same size" (42 U.S.C. 1396b(f)). But this delegation of authority plainly does not grant the Secretary the latitude to conclude that a family of three is the same size as a family of two. The "standards" that the Secretary was directed to prescribe are those establishing the State's determination as to which of its AFDC payment levels for a family of a given size is the "highest" that would "ordinarily be paid" to a family of that size. Once such standards have been employed, one can then multiply that "highest amount" by 133⅓ percent to derive the maximum Medicaid MNIL the State may establish for a family "of the same size" (42 U.S.C. 1396b(f)).

If, as the court below ruled, the Secretary may prescribe standards that treat two as equal to three, then the statutory requirement of equivalence is a nullity. "Read in this fashion," Judge Kozinski aptly put it, "the statute provides no limits whatsoever on the Secretary's discretion and might as well say 'the Secretary may set the MNIL any way he pleases' " (App., *infra*, 31a).

3. Even if the Secretary were thought to have discretion to prescribe standards under which a family of two would be deemed to be "the same size" as a family of three, the court of appeals plainly erred in concluding that the Secretary had in fact prescribed a "standard" in the

guise of HCFA's regional office manual. The court ruled that language contained in the 1979 version of the manual, language which was never published in the Federal Register or subjected to normal rulemaking procedures, and which was in conflict with the statutory mandate, was a "legislative rule" that "establishe[d] the right of states to increase their adult couple MNIL" (App., *infra,* 11a).

It is well settled that "not all agency publications are of binding force" (*Lyng* v. *Payne,* No. 84-1948 (June 17, 1986), slip op. 11). Indeed, if agencies were bound by every pronouncement made on their behalf, there would be no reason for Congress to have codified notice-and-comment procedures in the Administrative Procedure Act. Agency manuals in particular are examples of agency pronouncements that lack the force and effect of law. *Schweiker* v. *Hansen,* 450 U.S. at 789; *United States* v. *Caceres,* 440 U.S. 741 (1979); *Sullivan* v. *United States,* 348 U.S. 170, 172-174 (1954); *American Farm Lines* v. *Black Ball Freight Service,* 397 U.S. 532 (1970). In *Hansen,* a Social Security claims representative incorrectly told a claimant that she did not qualify for statutory insurance benefits; he also failed to advise her that she should file a written application for benefits, although the Social Security Claims Manual instructed claims representatives to give such advice. In refusing to estop the government from enforcing a lawful condition on the receipt of benefits, this Court acknowledged that the claims representative failed to follow the procedures provided for in the Claims Manual. The Court held, however, that "the Claims Manual is not a regulation * * * [i]t has no legal force, and it does not bind the [Social Security Administration]." 450 U.S. at 789. The Claims Manual, rather than being a compilation of binding regulations, was considered to be only a "handbook for internal use by thousands of SSA employees * * *." *Ibid.*

The court of appeals concluded that this case justified an exception to the established rule because, in the panel's view, the HCFA manual was not directed to office-level agency employees, but instead to "states and a major category of recipients under state plans" (App., *infra,* 11a). But, as the dissent demonstrates (*id.* at 28a (emphasis omitted)), the panel's rationale "flies in the face of [the manual's] own description of itself," for the manual explicitly says that it "is for the use of regional office employees only and should not be cited when addressing contractors, State agencies, providers, etc." Quite plainly, the manual was by its terms not intended for use by anyone other than HCFA employees—the same use for which the manual involved in *Schweiker* v. *Hansen* was intended. The court of appeals failed to acknowledge the manual's expressly limited purpose. And the court failed to explain how the manual, despite its explicit disclaimer, could be regarded as "a legislative rule issued pursuant to statutory authority" (App., *infra,* 16a).

4. The court's holding that the manual provision is a "regulation" becomes even more difficult to fathom when the manual is measured against the requirements that must be met before any agency publication has the force and effect of law. Ordinarily, published agency rules must "have certain substantive characteristics" and "be the product of certain procedural requisites." *Chrysler Corp.* v. *Brown,* 441 U.S. at 301. These include the procedural limitations and protections prescribed by the APA.

The manual provision upon which the court of appeals relied was never published in either the Federal Register or the Code of Federal Regulations. That nonpublication serves as a bright beacon showing that the agency did not regard the manual as its binding official interpretation. The United States Court of Appeals for the District of Columbia Circuit recently noted that an agency's "*[f]ailure* to publish in the Federal Register is [an] indication that the

statement in question was *not* meant to be a regulation," *Brock* v. *Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 538 (1986) (emphasis in original). "The real dividing point" between regulations and agency statements that are not regulations, the court continued, "is publication in the Code of Federal Regulations, which the statute authorizes to contain only documents having general applicability *and legal effect*" (*id.* at 539 (emphasis in original)).

A further reason why the manual provision cannot be regarded as a regulation is that the provision was never the subject of notice-and-comment rulemaking. The court below suggested that notice-and-comment procedures were not applicable here because the manual provision concerns matters relating to public benefits (see 5 U.S.C. 553(a)(2)). But in 1971 the Secretary had voluntarily waived the "public benefits" exception by formally stating that departmental regulations would comply with the statutory procedural requirements. Quite apart from the question whether this voluntary waiver is "binding" on the Secretary to the same degree as procedural requirements imposed directly by Congress (see App., *infra*, 14a), the Secretary's decision not to subject the HCFA manual to notice-and-comment procedures plainly shows that *the Secretary* did not regard that manual as a "regulation." And it is no answer to infer, as did the court of appeals (*ibid.*), that the Secretary in issuing the manual simply "failed to abide by her predecessor's promise to adopt the APA rulemaking procedures," for that is to posit a presumption of agency *irregularity*.

Another reason why the manual provision cannot be regarded as a regulation is that the provision was never published in the Federal Register, as both the FOIA and the APA require. Unlike the APA, the FOIA has no "public benefits" exception and therefore plainly mandates that regulations must be issued by publication. The court of appeals asserted that FOIA's publication require-

ment attaches only where nonpublication " 'would adversely affect a member of the public' " and hence concluded that the HCFA manual, although unpublished, was nevertheless a valid "legislative rule." App., *infra,* 15a (quoting *Zaharakis* v. *Heckler,* 744 F.2d 711, 714 (9th Cir. 1984)). But putting to one side the question whether an agency's failure to publish a regulation in the Federal Register will invariably invalidate it, the Secretary's action in not publishing the manual here plainly shows that the Secretary did not regard it as a "regulation" at all, least of all a regulation effectively revoking prior regulations duly promulgated under the APA.[4]

Finally, even if the manual provision were deemed to be a "regulation," the judgment below would still be incorrect. The language of the manual is so inconsistent with the Social Security Act that, as the HCFA Administrator concluded, it was "invalid from its origination" (App., *infra,* 44a). The judges dissenting on rehearing agreed, stating that the manual "violates the plain language of the statute" (*id.* at 30a). For this reason, even if the language in the manual reflected the Secretary's interpretation and satisfied all procedural requirements of rulemaking, it could not lawfully be given effect. *Morton* v. *Ruiz,* 415 U.S. 199 (1974).

5. The decision below would warrant this Court's review if the court of appeals had done nothing more to thwart congressional intent than subordinate the plain language of the statute and the consistent interpretation of the Secretary to contradictory language in an internal agency document. By itself, that holding would wreak

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[4] The court's alchemy in turning into a regulation something that is immutably not a regulation is further undermined by two basic principles of administrative law. First, properly enacted regulations – such as 42 C.F.R. 435.811 and 435.1007 – are binding on the government until properly repealed. *United States ex rel. Accardi* v. *Shaughnessy,* 347 U.S. 260, 267 (1954). Second, "the government cannot supersede regulations by means of internal operating instructions." *Flores* v. *Bowen,* 790 F.2d 740 (9th Cir. 1986); see *Schweiker* v. *Hansen,* 450 U.S. at 789.

havoc on federal agencies and on the public by casting into doubt the certainty that federal rules and regulations are set forth in the Code of Federal Regulations and the Federal Register. Under the decision below, those official compilations of departmental rules would be subject to contradiction, revision, or repeal by far less formal and certainly less official pronouncements made by lower level employees. That is not the law. *Schweiker* v. *Hansen, supra; Heckler* v. *Community Health Services,* 467 U.S. 51, 63-65 (1984); *FCIC* v. *Merrill,* 332 U.S. 380, 384 (1947).

But the court of appeals did more than that. It held that anonymous, internal agency pronouncements retain "the force and effect of law" unless "repealed" or, possibly, until "removed from publication" (App., *infra,* 13a, 16a). The manual provision at issue in this case was deleted from the superseding HCFA regional manual issued in July 1980, three years before California proposed the instant plan amendment. Until the decision below, one would have thought that an agency's revision of its office manual would terminate whatever binding effect a predecessor version might be deemed to have. Apparently not. Although the government in its petition for rehearing (at 9 n.3) advised the court of appeals that the HCFA manual had been revised and the relevant language deleted in 1980, the panel took no cognizance of that fact. The court seems to have held, in other words, that the Secretary must engage in formal notice-and-comment rulemaking to *revise* an office manual, even though the manual's supposed status as a valid "legislative rule" rested on the court's antecedent conclusion that notice-and-comment rulemaking was not required when the manual was issued in the first place.

6. The panel also erred in overturning the Secretary's determination on the alternative ground that the Secretary was barred by Section 2373(c) of DEFRA from disapproving California's proposed plan amendment. DEFRA im-

posed a moratorium to preclude the Secretary from taking regulatory action against state Medicaid plans that might be inconsistent with the "single standard" or "same methodology" language that had been added to 42 U.S.C. 1396a(a)(10)(C)(i)(III) by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378.[5] As this Court recently explained, in the context of the "same methodology" provision, the TEFRA language deals with determining what resources are to be regarded as income for purposes of Medicaid eligibility. *Atkins* v. *Rivera,* slip op. 8.

This Court's opinion in *Atkins* makes it clear (slip op. 11) that the relevant TEFRA amendment was intended "solely to invalidate" certain post-1981 regulations "permitting the income and resources standards in state Medicaid plans to deviate from those used [in other welfare programs]." Congress later sought to stay the Secretary's hand in implementing the "same methodology" language and enacted the DEFRA moratorium for that purpose. In so doing, Congress reaffirmed that its sole intent was to override regulations the Secretary had issued following the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 *et seq.* See H.R. Rep. 98-861, 98th Cong. 2d Sess. 1366-1368 (1984); *Atkins* v. *Rivera,* slip op. 12 n.10.[6]

The regulations at issue in this case were promulgated in 1978 (with predecessors dating back to 1971) and hence were not affected by TEFRA or the related DEFRA moratorium. Thus, the Secretary had no occasion to rely

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[5] That section requires a state to use the same methodology in determining eligibility for Medicaid as it would in determining eligibility for the categorically needy welfare programs and to use a single standard for determining income and resource eligibility for the medically needy.

[6] In contrast to the decision below, the Second Circuit, in another context, has correctly read the DEFRA moratorium in the circumscribed fashion of *Atkins* v. *Rivera.* See *Camacho* v. *Perales,* 786 F.2d 32, 42 (1986).

on the "single standard" or the "same methodology" provisions in disapproving California's proposed plan amendment. And, since the Secretary's action here was not an exercise of a power affected by the moratorium, the moratorium is totally irrelevant.

There is, ultimately, no conceivable reason why DEFRA, a deficit reduction measure, should be interpreted in a way that limits the Secretary's ability to enforce the statutory cap on federal financial participation in Medicaid. This case alone will result in a $50 million annual drain on the Treasury to fund one plan amendment in one state. A result so contrary to clearly expressed congressional intent should not be permitted to stand.[7]

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[7] The decision below has already had repercussions. The Secretary advises that at least one other state (Nebraska) has proposed to amend its plan in accordance with the California proposal in this case. In the Secretary's estimation, if the California amendment were adopted by all states participating in the Medicaid program, the added cost to the federal Treasury would be approximately $150 million. In addition, California has now proposed further plan amendments that would impose an additional burden on the federal fisc; under the court of appeals' holding on DEFRA, the Secretary may well be powerless to disapprove any of those proposals that are contrary to the statute.

Nor can the decision below be regarded as a sport. The Ninth Circuit has already relied on both alternative holdings in this case in a subsequent case in which it rejected the Secretary's implementation of a different portion of the Medicaid Act. *Vance* v. *Hegstrom*, 793 F.2d 1018 (1986).

## CONCLUSION

The petition for a writ of certiorari should be granted.
Respectfully submitted.

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NOVEMBER 1986

**APPENDIX A**

# UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

*v.*

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

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Argued and Submitted
August 14, 1985—San Francisco, California

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Filed February 7, 1986

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Before: Ben C. Duniway and Herbert Y. C. Choy, Senior Circuit Judges, and Jerome Farris, Circuit Judge.

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Opinion by Judge Duniway

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Petition for Review of a Decision of the Department of Health and Human Services

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**OPINION**

DUNIWAY, Senior Circuit Judge:

The California legislature increased the amount of income a medically needy adult couple can keep for non-medical needs and still be eligible to receive Medicaid. The State submitted this amendment of its Medicaid plan to Health and Human Services (HHS) Secretary Heckler, who disapproved it. The California Department of Health Services (the State) and the Legal Aid Society of Alameda County (Intervenors) challenge the Secretary's final determination. We reverse.

## I. *Facts.*

### A. The Medicaid Program.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, was established "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 1980, 448 U.S. 297, 301. In order to participate in the program, States must submit a plan to the Secretary, who shall approve any plan which fulfills the requirements set out in 42 U.S.C. §1396a(a). 42 U.S.C.

§ 1396a(b). Upon such approval, the State becomes entitled to Federal Financial Participation in state expenditures made in accordance with that plan. 42 U.S.C. § 1396b.

A State Medicaid Program must provide medical assistance to so-called categorically needy recipients of welfare benefits. 42 U.S.C. § 1396a(a)(10)(A). In addition, states may provide Medicaid coverage to so-called medically needy aged, blind and disabled people and families whose income is too high to allow them to qualify for welfare benefits. 42 U.S.C. § 1396a(a)(10)(C).

Each state Medicaid plan must set an income standard for medically needy recipients in accordance with Federal requirements. This "medically needy income level" (MNIL) represents the amount of income an individual or family may keep for non-medical needs and still be eligible to receive Medicaid.

B. *Medi-Cal Revisions.*

The California Medicaid plan (Medi-Cal) includes medically needy recipients. Hearings conducted by the California legislature in early 1983 suggested that aged and disabled medically needy recipients were unable to afford necessary medically care, as well as non-medical necessities, under current income standards. In response to findings that elderly and disabled adults incur greater living expenses than families with dependent children, the California legislature amended its Medicaid plan to increase the MNIL for a family of two medically needy adults to the highest amount that would ordinarily be paid to a family of three persons without any income or resources under its aid to families with dependent children (AFDC) plan. Statutes of 1983, Ch. 323, § 124.6(c) (codified at Cal. Welfare and Inst. Code § 14005.12(c)). The effect of this amendment was to increase the MNIL for adult couples from $544 to $709 per month. Ch. 323

further directed the State Director of Health Services to adopt regulations to implement the amended provisions as emergency regulations "necessary for the immediate preservation of the public peace, health and safety, or general welfare," Section 124.7(d), and provided that the amended provision would be inapplicable to the extent that it conflicts with federal law, Section 124.7(a). The State began implementing these revisions on November 1, 1983, effective July 1, 1983.

C. *The Secretary's Determination.*

The State submitted State Plan Amendment (SPA) 83-14 to its Title XIX Medicaid Plan, reflecting its revised adult couple MNIL. On December 19, 1983, the Administrator of the Health Care Financing Administration (HCFA) notified the State that SPA 83-14 was disapproved on the ground that it violated Section 1903(f) of the Social Security Act, 42 U.S.C. § 1396b(f).

Pursuant to 42 U.S.C. § 1316(a), the State petitioned the Secretary to reconsider HFCA's disapproval of SPA 83-14. On November 30, 1984, after a hearing was held, the Hearing Officer issued a Recommended Decision that the HCFA decision should be affirmed. On January 30, 1985, the HCFA Administrator, pursuant to delegated authority from the Secretary, issued her final decision affirming her initial disapproval of the plan amendment.

The State filed a timely petition for review by this court of the Secretay's final decision pursuant to 42 U.S.C. § 1316(a)(3). On April 1, 1985, this court granted a Motion to Intervene filed by the Legal Aid Society of Alameda County on behalf of several medically needy adult couples.

II. *Standard of Review.*

In reviewing the Secretary's disapproval of SPA 83-14, this court must decide all relevant questions of law and in-

terpret the statutory provisions at issue. 5 U.S.C. § 706. The Secretary's decision must be set aside if found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," § 706(2)(A); "in excess of statutory . . . authority," § 706(2)(C); or "without observance of procedure required by law," § 706(2)(D). The Secretary's interpretation of the Medicaid Act is entitled to deference, *FEC v. Democratic Senatorial Campaign Committee*, 1981, 454 U.S. 27, 31-32. However, "the courts are the final authorities on issues of statutory construction. They must reject administrative constructions of the statute . . . that are inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement." *Id.* at 32. *See also Livermore v. Heckler*, 9 Cir., 1984, 743 F.2d 1396, 1404-1405.

### III. Discussion.

#### A. Section 1903(f) and ROM § 2572-D.

Section 1903(f) of the Social Security Act, 42 U.S.C. § 1396b(f), states the limitation on Federal participation in medical assistance:

> (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is *the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to* 133⅓ percent of the highest amount which would ordinarily be paid to a family

> of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter [AFDC].

(emphasis added.)

This rule is further elaborated in the regulations implementing the statute:

> Medically needy income standards: General requirements.
>
> To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—
>
> (a) Based on family size;
>
> (b) Uniform for all individuals in a covered group;
>
> (c) For FFP [Federal Financial Participation] purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size; and
>
> (d) Reasonable.

42 C.F.R. § 435.811 (1984).

> Medically needy.
>
> (a) FFP is available in expenditures for services provided to medically needy recipients whose annual income . . . does not exceed the following amounts . . .
>
> (1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources.

42 C.F.R. § 435.1007.

The Administrator disapproved SPA 83-14 on the grounds that it violated the "plain and unequivocal" language of Section 1903(f) and the above regulations. However, the Administrator's narrow reading of the

statute fails to recognize sufficiently the substantive component of the MNIL determination. Section 1903(f) does not simply fix the applicable MNIL at 133⅓ percent of the highest amount ordinarily paid to a family of the same size without income or resources under a State's AFDC plan. The section provides that the applicable MNIL is "*the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to*" 133⅓ percent of the highest amount ordinarily paid to a family of the same size under AFDC. 42 U.S.C. § 1396b(f)(1)(B)(i) (emphasis added.) Had Congress intended that MNILs be determined purely as a mathematical procedure, it would not have included the above clause, which requires the Secretary to prescribe standards for determining an "equivalent" MNIL in relation to the comparative needs of medically needy and AFDC families of the same size. *See Batterton v. Francis*, 1977, 432 U.S. 416, 428: "Congress itself must have appreciated that the meaning of the statutory term was not self-evident, or it would not have given the Secretary the power to prescribe standards."

In response to a state's request "for a clarification of policy" regarding the establishment of MNILs under Section 1903(f), HHS promulgated Regional Office Manual (ROM) § 2572-D in June 1979. CCH Medicaid and Medicare Guide, ¶ 30,392 at 9512-13. This ROM provision set out HHS policy as to the specific problem addressed by the California plan amendment at issue here: the comparable income levels of medically needy adults and those of children in families receiving assistance under AFDC. Citing documentation that the maintenance needs of these groups are not equivalent, ROM § 2572-D states that "the States may set a separate medically needy income level for two adults which would be established between 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three

persons." HHS cites Montana as an example of a state which properly established an adult couple MNIL above the state AFDC level for a family of two. The ROM section concludes:

> In view of the greater maintenance needs of an adult as opposed to a child, . . . and in the interest of comparable treatment of persons with similar needs, the States should have the option of establishing separate medically needy income levels for a two-person family consisting of one adult and one child and for a two-person family composed of two adults.

In disapproving SPA 83-14, the Administrator rejected the State's reliance on ROM § 2572-D on the ground that "[t]he ROM section is patently contrary to the statute and was, therefore, invalid from its origination." This conclusion is based upon the improperly narrow construction of Section 1903(f) noted above. ROM § 2572-D is entirely consistent with the statutory requirement that the Secretary may promulgate standards for determining "equivalent" income limitations.

The Secretary also argues that the amendment is invalid under the ROM language allowing states to adopt an MNIL "between" 133⅓ percent of the AFDC payment level for one person and 133⅓ percent of the AFDC payment level for a family of three persons. Under the Secretary's view, SPA 83-14 would presumably have fulfilled the ROM criteria if California had set the adult couple MNIL at "one dollar less than" the maximum set out in the ROM section. However, ROM § 2752-D may be reasonably construed to include the maximum amount. The California plan amendment is therefore consistent with the ROM section.

Agencies must comply with their own regulations. *Ramon-Sepulveda v. INS*, 9 Cir., 1984, 743 F.2d 1307, 1310; *Dyniewicz v. United States*, 9 Cir., 1984, 742 F.2d 484, 485, even when the regulations are more generous

than required by law, *United States v. Newell*, 9 Cir., 1978, 578 F.2d 827, 834. However, "[n]ot all agency policy pronouncements which find their way to the public can be considered regulations enforceable in federal court." *Rank v. Nimmo*, 9 Cir., 1982, 677 F.2d 692, 698, quoting *Chasse v. Chasen*, 1 Cir., 1979, 595 F.2d 59, 62. The Secretary argues that the ROM is not a regulation, has no legal force and does not bind HCFA, citing the Hearing Officer's Recommended Decision. Appellants argue that whether the ROM section is labeled a "regulation," "directive" or "guideline," California had the right to rely on it in formulating SPA 83-14 and the Secretary must abide by its terms absent a proper repeal.

For ROM § 2572-D to have the "force and effect of law," it must satisfy both of the requirements set out by the Supreme Court in *Chrysler Corp. v. Brown*, 1979, 441 U.S. 281, 301-304. First, it must prescribe "substantive" or "legislative" rather than "interpretive" rules. *Id.* at 301-303. Second, its promulgation "must conform with any procedural requirements imposed by Congress." *Id.* at 303. *See also Rank, supra*, 677 F.2d at 698. We hold that ROM § 2572-D meets both parts of the *Chrysler* test and therefore bars the Secretary from disapproving the California plan amendment.

1. ***Legislative v. Interpretive Rules.***

Substantive or "legislative-type" rules are ones "affecting individual rights and obligations." *Chryser, supra*, 441 U.S. at 302, which "effect a change in existing law or policy," *Powderly v. Schweiker*, 9 Cir., 1983, 704 F.2d 1092, 1098, and which are "issued by an agency pursuant to statutory authority . . . and implement the statute, as, for example, the proxy rules issued by the Securities and Exchange Commision. . . " *Chrysler* at 302-3, citing *Batterton v. Francis, supra*, 432 U.S. at 425 n.9. *See also Alcaraz v. Block*, 9 Cir., 1984, 746 F.2d 593, 613; *Fmali*

*Herb, Inc. v. Heckler*, 9 Cir., 1983, 715 F.2d 1385, 1387. On the other hand, an interpretive rule is one issued without delegated legislative power. *Id.* at 1387. Such rules

> are essentially hortatory and instructional in that they go more 'to what the administrative officer thinks the statute or regulation means' *Gibson Wine Co. v. Snyder*, 194 F.2d 329, 331 (D.C. Cir. 1952), when applied in particular, narrowly defined situations. . . By merely clarifying the law's terms as applied situationally, interpretive or administrative-type rules are used more for discretionary fine-tuning than for general law making.

*Alcaraz, supra*, 746 F.2d at 613.

The Secretary describes ROM 2572-D as merely an "interpretive guideline." The label that an agency chooses to describe its action is "only indicative and not dispositive, of the agency's intent," which may be inferred from the forseeable effect that the rule will have. *Louisiana-Pacific Corp. v. Block*, 9 Cir., 1982, 694 F.2d 1205, 1210. Neither is the fact that the Secretary published this provision in the Regional Office Manual, and failed to do so in the Federal Register, dispositive on this issue. *See e.g., United States v. Coleman*, 9 Cir., 1973, 478 F.2d 1371.

The Secretary argues that the HCFA Regional Office Manual, like the SSA Claims Manual in *Schweiker v. Hansen*, 1981, 450 U.S. 785,

> is not a regulation. It has no legal force, and it does not bind the SSA. Rather it is a 13-volume handbook for internal use by thousands of SSA employees, including the hundreds of employees who receive untold numbers of oral inquiries like respondent's each year.

*Id.* at 789. The Supreme Court in *Schweiker* held that the "minor breach" of a provision in this manual by an SSA field representative (failure to follow a provision instructing representatives to advise applicants of the advantage

of filing written applications) did not estop the SSA from denying the applicant retroactive benefits according to a regulation limiting such benefits to one who "has filed [written] application." *Id.* at 786, 789. Referring to *Schweiker v. Hansen,* this court has held that other SSA claims manual provisions do not have "the force and effect of law." *Powderly,* 704 F.2d at 1096, 1098; *Whaley v. Schweiker,* 9 Cir., 1981, 663 F.2d 871, 873. Each of the above rules are interpretive, in that they instruct agency employees how the agency thinks a particular statue or regulation should be applied "in particular, narrowly defined situtations." *Alcaraz, supra,* 746 F.2d at 613. "These provisions only explain what the more general terms of the Act and regulations already provide." *Powderly, supra,* 704 F.2d at 1098.

It is clear that agency office manuals generally do not prescribe legislative rules with binding effect. However, the ROM section at issue in this case is an exception. Unlike the office manual provision in the above cases, ROM § 2572-D is not a field-level instructional guide to the application of the statute with respect to the inquiries and circumstances of particular individuals. It is directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans. It establishes the right of states to increase their adult couple MNIL and thereby affects the rights of medically needy adults in all states with a Medicaid program. It establishes a new MNIL maximum in this category and thereby "effect[s] a change in existing law or policy," *Powderly, supra,* 704 F.2d at 1098. Most importantly, this case is distinguished from the cases cited by the Secretary by the statutory basis for the promulgation of ROM § 2572-D.

The question whether a given rule is legislative or interpretive turns on whether it is one "issued by an agency pursuant to statutory authority and . . . implement[s] the

statute," *Batterton, supra,* 432 U.S. at 425 n.9, or one "issued pursuant to an agency's interpretation of a governing statute without delegated power." *Fmali Herb, supra,* 715 F.2d at 1387. *See also Alcaraz, supra,* 746 F.2d at 613; *Louisiana-Pacific Corp., supra,* 694 F.2d at 1210.

In *Batterton,* the Supreme Court upheld a challenged regulation promulgated by the Secretary of HEW "pursuant to a delegation of rulemaking authority" in § 407(a) of the Social Security Act, 42 U.S.C. § 607(a). Like Section 1903(f) at issue in this case, Section 407(a) directed that a statutory term be "determined in accordance with standards prescribed by the Secretary."[1] The Supreme Court held that Congress "expressly *delegated* to the Secretary power to prescribe standards" for determining what constituted "unemployment" for purposes of program eligibility. *Id.* at 425 (emphasis in original).

> In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect.

*Id. See also Herweg v. Ray,* 1982, 455 U.S. 265, 274-75; *Schweiker v. Gray Panthers,* 1981, 453 U.S. 34, 44. Noting that the Secretary's statutory authority to prescibe standards is not unlimited, the *Batterton* Court declared

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[1] 42 U.S.C. § 607. Dependent children of unemployed father; definition.

> "(a) The term 'dependent child' shall, notwithstanding section 606(a) of this title, include a needy child who meets the requirements of section 606(a)(2) of this title who has been deprived of parental support or care by reason of unemployment (*as detemined in accordance with standards prescribed by the Secretary*) of his father, and who is living with any of the relatives specified in section 606(a)(1) of this title in a place of residence maintained by one or more of such relatives as his (or their) own home." Cited in *Batterton,* 431 U.S. at 418 n.2 (emphasis added).

"we cannot say that the Secretary's regulation defeats the purpose of the [benefit] program" and upheld the regulation. *Batterton,* 432 U.S. at 429.

Unlike the statutes interpreted by the agency manuals in the cases cited by the Secretary, Section 1903(f) expressly authorized the Secretary to prescribe "standards." Congress must have intended that standards thus prescribed by HHS would have the force and effect of law. In promulgating the ROM provision at issue, the Secretary followed the mandate of Section 1903(f). This provision on its face sets out standards for determining "equivalent" adult couple MNILs in relation to payment levels under state AFDC plans. ROM § 2572-D is therefore a rule "issued by an agency pursuant to statutory authority and . . . implements the statute," *Batterton, supra,* 432 U.S. at 425 n.9. Because we cannot say that it defeats the purpose of the Medicaid program, *id.* at 428-29, we conclude that ROM § 2572-D is a proper legislative rule.

2. ***Procedural Requirements Imposed by Congress.***

Once an agency rule or regulation has been determined to be substantive, it nevertheless will not have "the force and effect of law" unless its promulgation conforms "with any procedural requirements imposed by Congress." *Chrysler Corp., supra,* 441 U.S. at 303.

Notice and comment procedures set out in the Administrative Procedure Act (APA) generally apply to agency rulemaking with the exception of "interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. § 553(b)(A). ROM § 2572-D was not promulgated according to APA procedures. However, the APA requirements do not apply "to the extent there is involved . . . a matter relating to . . . public property, loans, grants, *benefits,* or contracts." 5 U.S.C. § 553(a)(2) (emphasis added). The ROM section at issue expressly concerns Medicaid, a

benefit program, and falls under the statutory exemption, *Cf. Good Samaritan Hospital, Corvalis v. Mathews,* 9 Cir., 1979, 609 F.2d 949, 953-54; *Baylor University Medical Center v. Heckler,* 5 Cir., 1985, 758 F.2d 1052, 1058; *Bedford County General Hospital v. Heckler,* 6 Cir., 1985, 757 F.2d 87, 90; *Humana of South Carolina v. Califano,* D.C., Cir., 1978, 590 F.2d 1070. 1083-84 & n.102. *See also Alcaraz v. Block, supra,* 746 F.2d at 611.

The Secretary voluntarily waived the APA "benefits" exception in 1971. 36 Fed. Reg. 2532 (1971); *Good Samaritan Hospital, supra,* 609 F.2d at 954. The Department thereby imposed upon itself procedural requirements "not required by law." 36 Fed. Reg. 2532. The Secretary's waiver has a binding effect independent of the APA, *see Buschman v. Schweiker,* 9 Cir., 1982, 676 F.2d 352, 356 n.4; *cf. Rodway v. Department of Agriculture,* D.C. Cir., 1975, 514 F.2d 809, 814, and would operate to invalidate a challenged substantive rule limiting benefits promulgated in violation of the requirements set out in the APA. However, the 1971 waiver does not overrule or otherwise abrogate Section 553(a)(2), a section which has not been repealed and remains in effect. "[R]ulemaking requirements for agencies managing benefit programs are still voluntarily imposed—i.e., agency-created statutory exceptions. Thus, it is only the Department's own statement of policy that applies the notice and comment provisions to rulemaking in these programs." *Alcaraz, supra,* 746 F.2d at 611. In promulgating ROM § 2572-D, the Secretary failed to abide by her predecessor's promise to adopt APA rulemaking procedures. Nevertheless, these were not "procedural requirements imposed by Congress." *Chrysler Corp., supra,* 441 U.S. at 303.

The APA procedural requirements exist to protect the public's interests, not to shelter the Secretary. As the D.C. Circuit stated, "The essential purpose of according § 553 notice and comment opportunities is to reintroduce public

participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies." *Batterton v. Marshall,* D.C. Cir., 1980, 648 F.2d 694, 703. This case does not involve a defectively promulgated regulation challenged by members of the public who claim that they were harmed by losing their right to participate in the administrative rulemaking process. On the contrary, the State and Intervenors emphasize that they had full awareness of the promulgation and existence of ROM § 2572-D. The Secretary does not dispute this. She argues that the ROM section is an "interpretive guideline" that need not be published under the APA or Freedom of Information Act (FOIA), but she also argues that, because California had actual and timely notice of the ROM terms, lack of publication should not be fatal, citing *United States v. Mowat,* 9 Cir., 1978, 582 F.2d 1194, 1201. *See also United States v. Hall,* 9 Cir., 1984, 742 F.2d 1153, 1155; *Nason v. Kennebec County CETA,* 1 Cir., 1981, 646 F.2d 10, 19.

The FOIA requires agencies to publish in the Federal Register not only "substantive rules of general applicability adopted as authorized by Law" but also "statements of general policy or interpretation of general applicability formulated and adopted by the agency," 5 U.S.C. § 552(a)(1)(D) and "each amendment, revision, or repeal of the foregoing," § 552(a)(1)(E). There is no "benefits" exemption from the FOIA publication requirement. However, this requirement "attaches only to matters which if not published would adversely affect a member of the public." *Zaharakis v. Heckler,* 9 Cir. 1984, 744 F.2d 711, 714, citing *Hogg v. United States,* 6 Cir., 1970, 428 F.2d 274, 280. The Secretary's failure to publish the ROM provision in 1977 in accordance with the FOIA therefore does not affect the validity of the provision. *See Rodriguez v. Swank,* 318 F.Supp. 289, 295, *aff'd* 403 U.S. 901.

We conclude that ROM § 2572-D meets both prongs of the *Chrysler* test. It is a legislative rule issued pursuant to statutory authority; its promulgation violated no procedural requirements imposed by Congress. The ROM provision became effective June 1979. When the California legislature enacted SPA 83-14 it had not been properly repealed by HHS nor even removed from publication. ROM § 2572-D therefore had "the force and effect of law," *Chrysler, supra,* 441 U.S. at 301-305, and barred the Secretary from disapproving the California plan amendment which conformed to its terms.

**B.** ***The Deficit Reduction Act (DEFRA).***

The Act, Pub. L. 98-369, Section 2373(c) provides an additional, independent reason for reversal. This section established a moratorium during which the HHS Secretary

> shall not take any compliance, disallowance, penalty, or other regulatory action against a State . . . by reason of such state's [Medicaid] plan . . . being determined to be in violation of [Social Security Act] section 1902(a)(10)(C)(i)(III).

DEFRA Section 2373(c)(1). This moratorium began when DEFRA was enacted in July, 1984, before the Secretary's final disapproval of SPA 83-14 in January, 1985. It continues until 18 months after the Secretary reports to Congress as required by DEFRA Section 2373(c)(3). Section 2373(c)(2).

Section 1902(a)(10)(C)(i)(III), adopted as a provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) requires that a state medicaid plan which provides benefits to medically needy recipients include a description of

> the single standard to be employed in determining income and resource elegibility for all such groups, in the methodology to be employed in determining such eligibility, which shall be the same methodology

> which would be employed under the . . . appropriate State [cash assistance] plan. . . .

42 U.S.C. § 1396a(a)(10)(C)(i)(III).

Appellants argue that the DEFRA moratorium applies directly to prevent the Secretary from rejecting the California Medi-Cal amendment. They point out that prior to the Administrator's disapproval of SPA 83-14, HCFA stated in agency memoranda and in a letter to the State that such a plan would violate the "single standard" requirement of TEFRA. The Secretary correctly points out that neither the initial nor final decisions disapproving SPA 83-14 expressly claim that the plan amendment violated TEFRA. Her decision relies entirely on the argument that the California plan violated Section 1903(f). However, the California plan amendment raises exactly the kind of problem which Congress addressed by establishing a moratorium on HHS implementation of the TEFRA "single standard" provision.

The California legislature enacted the Medicaid plan amendment in response to findings that a single standard did not accurately reflect the comparative need of medically needy adults and children in families receiving assistance under AFDC. Although the Administrator's final decision did not expressly cite Section 1902(a)(10)(C)(i)(III), that decision nevertheless recognized that the California plan amendment raises a TEFRA "single standard" issue.

> *Regardless of the possibly greater maintenance needs of a two-adult family as opposed to an AFDC family of two (one child, one adult),* the statute provides for a single MNIL for a family of two.

Decision of the Administrator at 4 (emphasis added).

Congress intended the DEFRA moratorium to apply in precisely this situation. The DEFRA Conference Committee Report explains that Section 2373 was enacted to cor-

rect HHS's "overly restrictive" interpretation of the TEFRA provision. 130 Cong. Rec. H6741 (daily ed. June 22, 1984). One of the examples cited by the conferees corresponds directly to the facts of this case:

> [T]he Department has taken the position, that the 'single standard' requirement of the TEFRA amendment prohibits States from establishing less restrictive medically needy income levels for single adults and couples because this would result in differences in medically needy income levels among groups of the same size depending on the relative members of adults and children.

*Id.* The Conference Report explains that Congress enacted Section 2373 to prevent the Secretary from taking, during the moratorium period, "any compliance, disallowance, penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, is using *an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology.*" *Id.* (emphasis added.) There is no statutory basis for the Secretary's argument that the DEFRA moratorium applies only to already "existing and approved plans." In disapproving SPA 83-14, the Secretary improperly penalized California, in violation of DEFRA Section 2373(c), for adopting a different, less restrictive methodology than that used under the California AFDC plan for a family of two.

### IV. *Conclusion.*

The California Medicaid plan amendment at issue conforms to the MNIL standards prescribed by the Secretary pursuant to Section 1903(f) of the Social Security Act, set out in ROM § 2572-D. The Secretary's determination that SPA 83-14 violates Section 1903(f) is therefore arbitrary and capricious. Moreover, the Secretary's disapproval of

SPA 83-14 violates DEFRA Section 2373(c) and is therefore not in accordance with law.

Because we reverse the Secretary's final determination on statutory grounds, we need not reach the due process claim raised by Intervenors.

The Secretary's decision disapproving SPA 83-14 is REVERSED.

**APPENDIX B**

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

*v.*

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

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Filed March 6, 1986

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**ORDER**

Before: DUNIWAY, CHOY, and FARRIS,
*Circuit Judges*

It is hereby ordered that the next to the last line on page 5 of the slip opinion in this case is amended to read as follows:

> of two medically needy adults to 133-⅓% of the highest amount that . . .

**APPENDIX C**

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 85-7123 (CA SP 83-14)

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN & LOLA BIERMAN, ET AL.,
PETITIONERS-INTERVENORS,

*v.*

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

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Mandate Issued July 23, 1986

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File and Entered: Feb. 7, 1986

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**PETITION FOR REVIEW OF A DECISION OF THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES**

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**JUDGMENT**

This Cause came on to be heard on the Transcript of the Record from the Department of Health and Human Services, and was duly submitted.

On Consideration Whereof, it is now here ordered and adjudged by this Court, that the Order of the said Department of Health and Human Services in this Cause be, and hereby is REVERSED.

**APPENDIX D**

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

*v.*

OTIS R. BOWEN, M.D. (FORMERLY MARGARET HECKLER),
SECRETARY, DEPARTMENT OF HEALTH AND HUMAN
SERVICES, UNITED STATES OF AMERICA, RESPONDENT.

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Filed July 14, 1986

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**ORDER**

Before: DUNIWAY, CHOY, and FARRIS,
*Circuit Judges*

A member of this court having called for a vote on taking this case in banc, and a majority of the members having voted against taking the case in banc, the suggestion of a rehearing in banc is rejected, and the petition for a rehearing is denied.

**APPENDIX E**

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 85-7123

STANLEY CUBANSKI, DIRECTOR,
DEPARTMENT OF HEALTH SERVICES
STATE OF CALIFORNIA, PETITIONER,

AND

DONALD A. BARRIER, ALAN BIERMAN, LOLA BIERMAN,
JAMES JONES, RONALD KWIEK, PETITIONERS-INTERVENORS,

*v.*

MARGARET HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
UNITED STATES OF AMERICA, RESPONDENT.

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Filed July 18, 1986

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**DISSENT**

KOZINSKI, *Circuit Judge,* with whom Circuit Judges SNEED, HALL and NOONAN join, Dissenting from the rejection of the suggestion for rehearing en banc.

The panel's opinion in this case is a study in judicial legislation. Disregarding principles of administrative law long established by the Supreme Court and this court, the opinion gives birth to a sweeping new doctrine: that a federal court may endow an agency's internal operating manual with the force of law. In so doing, the panel fails to acknowledge that the manual in question was prepared by government employees lacking authority to issue regulations; was expressly limited to use within the agency; and contravened properly issued regulations, that the

panel over-rules *sub silentio*. Equally unprecedented is the panel's alternative ruling, reversing the Secretary for the curious reason that his decision cannot be sustained under an inapplicable statute on which he did not rely. It is difficult to reconcile the opinion's tortuous path with the Supreme Court's admonition that administrative decisions not be set aside "simply because the court is unhappy with the result reached." *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519, 558 (1978).

Aside from the severe financial impact this case will have by its own force—the government estimates $50 million annually, Pet. Reh. at 1 n.1—its precedential effect as the law of the nation's largest circuit is difficult to overestimate. The opinion seriously blurs lines dividing regulations from other agency issuances, and separating those employees who may lawfully bind the agency from those who may not. By making every federal agency's operating manuals and internal guidelines fair game to a claim that they carry the force of law, the opinion will wreak havoc with administrative decision-making, and shift significant power from the Executive Branch to the courts.

These arguments, and others discussed below, are advanced crisply and persuasively in Respondent's Petition for Rehearing with Suggestion for Rehearing En Banc. They remain unanswered and, to my mind, unanswerable. Yet answers they deserve. If the panel is unwilling or unable to address these contentions, the full court should. Because I believe the court did not live up to its grave responsibility for maintaining the fabric of the law intact, I respectfully dissent.

## FACTS

This case concerns the extent of federal participation in Medi-Cal, California's version of Medicaid. Title XIX of

the Social Security Act, 42 U.S.C. § 1396 *et seq.* (1982 & Supp. 1985), sets standards for such participation. Specifically, a state must provide medical assistance to recipients of welfare benefits. 42 U.S.C. § 1396a(a)(10)(A) (1982). In addition, a state may provide Medicaid coverage to various groups (e.g. the aged, blind or disabled) who are ineligible for welfare because their income is somewhat too high, but who are nevertheless poor. These people are deemed "medically needy." *Id.* §§ 1396a(a)(10)(C), 1396d. Each state must define who is medically needy in accordance with federal standards, *id.* § 1396a(a)(10)(C)(i); the income standard for such recipients is known as the "medically needy income level" or MNIL.

At issue in this case is California's attempt to loosen the standards for Medi-Cal eligibility by increasing the MNIL for a family of *two* medically needy adults to 133-⅓% of the highest amount that would be paid to a family of *three* under AFDC. The Health Care Financing Administration (HCFA) disapproved the proposed revision because it violated 42 U.S.C. § 1396b(f) (1982). The Secretary affirmed.

A panel of this court reversed, basing its decision on alternative rulings. First, the panel concluded that the Secretary's interpretation of section 1396b(f) was inconsistent with a section of HCFA's Regional Office Manual (ROM). The panel held that this provision was a legislative regulation and interpreted it as allowing California's increase in the MNIL. The panel also held that the Secretary's action was barred by section 2373(c)(1) of the Deficit Reduction Act (DEFRA), Pub. L. 98-369, which imposes a moratorium on certain regulatory actions against state Medicaid plans.

## DISCUSSION

1. *The Statute, the Regulation and the ROM*

The statute provides that a family's MNIL is "the amount determined, in accordance with standards prescribed by the

Secretary, to be equivalent to 133-⅓ percent of the highest amount which would ordinarily be paid [under AFDC] to a family of the *same* size without any income or resources[.]" 42 U.S.C. § 1396b(f)(1)(B)(i) (1982) (emphasis added). The panel rejected the Secretary's argument that this section limited the MNIL to 133-⅓% of the maximum AFDC payment families of the *same* size could receive, pointing to the phrase "in accordance with standards prescribed by the Secretary." The panel reasoned that this language allows the Secretary to devise a formula permitting states to set the MNIL at more than 133-⅓% of the maximum amount payable under AFDC to families of the same size. The panel then held that HCFA's Regional Office Manual § 2572-D is that formula. It interpreted this ROM section as allowing the State to set the MNIL in terms of the income of an AFDC family of a different size. The panel rejected the Secretary's attempt to repudiate this ROM section. It held that the provision is a legislative regulation, having the force and effect of law, binding on the Secretary. 781 F.2d at 1424-29. The panel errs in almost every respect.

A.

Most fundamentally, the Regional Office Manual is not a body of regulations. As its name suggests, the ROM is an *office manual,* an internal directive from the agency's headquarters to its field offices. The manual's Foreword emphasizes this point:

> The Health Insurance Regional Office Manual (ROM) is the principal channel for transmitting program instructions of on-going reference value to regional offices. . . .

> The ROM is not intended to stand alone but rather to serve as the regional supplement to other health insurance manuals; e.g., provider manuals, intermediary manuals. Therefore, substance in other issuances will not generally be repeated. Appropriate cross-references will be used instead.
>
> . . . .
>
> This manual is for the use of regional office employees only and should not be cited when addressing contractors, State agencies, providers, etc.

HCFA Regional Office Manual Part 6 (Medicaid) iii.

As the panel recognizes, numerous cases in the Supreme Court and this court stand for the proposition that the contents of such manuals are not regulations, have no legal force and do not bind the agency. *See Schweiker* v. *Hansen,* 450 U.S. 785, 789 (1981) (SSA Claims Manual); *Powderly* v. *Schweiker,* 704 F.2d 1092, 1096, 1098 (9th Cir. 1983) (same); *Whaley* v. *Schweiker,* 663 F.2d 871, 873 (9th Cir. 1981) (same); *see also Evelyn* v. *Schweiker,* 685 F.2d 351, 352 n.5 (9th Cir. 1982) (Program Operations Manual System). The panel cites no case to the contrary and careful research reveals none.

The panel's attempt to distinguish these cases is far off the mark. For example, it states:

> Unlike the office manual provision in the above cases, ROM § 2572-D is not a field-level instructional guide to the application of the statute with respect to the inquiries and circumstances of particular individuals. It is directed not at office-level agency employees and specific recipients but at states and a major category of recipients under state plans.

781 F.2d at 1426-27. The panel gives no citation for this counterintuitive assertion. Nor do I believe it could, since

it flies in the face of the ROM's own description of itself: "This manual is for the use of regional office employees only and *should not be cited when addressing* contractors, *State agencies,* providers, etc." ROM Pt. 6, at iii (emphasis added).

One searches the opinion in vain for an explanation of how the panel's ruling can be squared with this disclaimer, or even an acknowledgment that the disclaimer exists. Nor does the panel explain why something called an office manual would contain procedures "directed not at office-level agency employees . . . but at states and a major category of recipients under state plans." 781 F.2d at 1426-27.

The panel goes on to assert that the ROM "establishes the right of states to increase their adult couple MNIL" and "thereby 'effect[s] a change in existing law or policy [.]' " *Id.* at 1427 (quoting *Powderly,* 704 F.2d at 1098). But this merely assumes the conclusion. A provision can effect a change in existing law or policy only if it has the force of law; if it does not, it cannot.

The panel further claims that the ROM has the force of law because it has a "statutory basis:"

> Unlike the statutes interpreted by the agency manuals in the cases cited by the Secretary, Section 1903(f) expressly authorized the Secretary to prescribe "standards." Congress must have intended that standards thus prescribed by HHS would have the force and effect of law. In promulgating the ROM provision at issue, the Secretary followed the mandate of Section 1903(f).

*Id.* at 1427. But words on paper do not become legislative regulations merely because the Secretary could have promulgated them as such; he must actually have done so. The Secretary, however, denies doing any such thing, and all available evidence supports his claim.

Congress granted the authority to promulgate rules and regulations to the Secretary alone, *see* 42 U.S.C. § 1302 (1982), authority he has jealousy retained.[1] There is absolutely no indication that the Secretary had anything to do with writing or approving HCFA's Regional Office Manual, or any part of it. The Regional Office Manual is a publication of HCFA, an operating division of HHS. Like thousands of other internal guidelines issued every year by scores of federal agencies, ROM updates are issued anonymously; the Foreword alone is signed and that by the Director of the Bureau of Health Insurance, an official far subordinate to the Secretary. ROM Pt. 6, at iv. Guidelines issued by someone without authority to promulgate regulations are simply not regulations. *See General Electric Co.* v. *Gilbert,* 429 U.S. 125, 141 (1976). This alone conclusively refutes the panel's assertion that ROM § 2572-D was promulgated pursuant to the authority of Section 1396b(f) and is binding on the Secretary. 781 F.2d at 1427.

But there is much more. The Secretary in fact *has* promulgated regulations on this very subject, regulations that plainly conflict with ROM § 2572-D and the panel's decision. *See* 42 C.F.R. §§ 435.811, .1007 (1985). These regulations provide that federal participation

> is available in expenditures for services provided to medically needy recipients whose annual income . . . does not exceed the following amounts . . . : (a) For couples and families of two or more, 133-⅓ percent of the highest money payment that would ordinarily

[1] While the Secretary had made various delegations to the Administrator of HCFA by the time ROM section 2572-D was issued, he specifically retained the authority to issue regulations, 44 Fed. Reg. 31045 (May 30, 1979) (Statement of Organization, Functions, and Delegations of Authority).

> be made under the State's AFDC plan *to a family of the same size* without income and resources.

*Id.* § 435.1007 (emphasis added). The ambiguity the panel detected in the statutory language is neatly excised by these regulations. The regulations are a valid exercise of the Secretary's authority and therefore have the force of law. To conclude, as the panel in effect does, that the Regional Office Manual takes precedence, violates the axiom that federal regulations may not be contravened by subordinate employees who lack authority to bind the agency. *Federal Crop Insurance Corp.* v. *Merrill,* 332 U.S. 380, 384-85 (1947). In any collision between regulations and instructions in an office manual, the regulations must prevail. Moreover, the very existence of conflicting regulations issued by the Secretary contradicts the panel's assertion that the anonymous ROM update represented the Secretary's exercise of authority pursuant to 42 U.S.C. § 1396b(f).

The panel's opinion quotes the regulations, 781 F.2d at 1424, but ignores them; it does not attempt to reconcile the obvious conflict between the regulations and ROM § 2572-D, the linchpin of its decision; it does not even acknowledge the tension between the two. The panel effectively reads the regulations out of existence without any explanation or admission of the fact.

**B.**

Even if ROM § 2572-D had been promulgated as a regulation, it would be invalid because it violates the plain language of the statute. While section 1396b(f)(1) gives the Secretary discretion to determine how the MNIL amount is to be calculated, the calculation must in fact aim at approximating the AFDC income of a family of the *same* size. It renders language meaningless to say, as does the panel, that the Secretary may formulate the MNIL in

terms of the amount to be paid to a family of a *different* size.[2] Read in this fashion, the statute provides no limits whatsoever on the Secretary's discretion and might as well say "the Secretary may set the MNIL any way he pleases."

C.

Troubling as I find the panel's result, it is its method, with its explosive potential, that causes me the greatest alarm. I had thought it firmly established that a court may not roam through the vast libraries of federal agency publications, borrowing from those it likes and ignoring the rest. Agency publications come in many forms and levels of dignity—from press releases to regulations promulgated after notice and comment; and they are issued by a variety of agency officials—from GS-15 field office chiefs to Cabinet Secretaries. Regulations properly issued by a Cabinet Secretary pursuant to authority delegated to him by Congress, I had thought, took precedence over all other agency issuances and, unless held to be invalid, conclusively resolve the legal issues they address. I had also thought that an agency could safely issue internal guidance to its employees without binding itself to outsiders by: (a) confining issuances to internal procedure manuals; (b) failing to attribute them to anyone with authority to promulgate regulations; and (c) expressly disclaiming the intent to promulgate regulations.

The panel's opinion tears asunder these tenets of administrative law, replacing them with nothing more substantial than its assurance that ROM § 2572-D is "an exception." 781 F.2d at 1426. But the panel gives no accurate account of what makes it an exception; everything it says about ROM § 2572-D could fairly be said about a great many other office manuals issued by federal agen-

[2] In certain limited circumstances section 1396b(f)(1)(B)(ii) allows the Secretary to set the MNIL amount higher than 133-⅓% of the

cies. Lawyers in the nine western states will now have a field day prospecting for other such nuggets within the thousands of pages of internal instructions issued by agencies regulating vast areas of the law: tax, personnel, transportation, agriculture, the environment, to name a few.

Having created uncertainty where stability is vital, the panel's methodology will breed litigation which will then beget further uncertainty. While this may be a bonanza for lawyers, and give immense power to courts to meddle in the affairs of the Executive Branch, it will cause no end of headaches for agency officials who will now have to guess which of their informal, unsigned, internal guidelines will be found "exceptional" enough to outrank regulations. That door, it seems to me, was slammed shut by the Supreme Court in cases such as *Schweiker* v. *Hansen* and *Federal Crop Insurance* v. *Merrill*. It should remain that way.

2. *The Deficit Reduction Act (DEFRA)*

A.

Perhaps not entirely comfortable with its principal ruling, the panel offers an alternative: that the Secretary's action violated DEFRA's moratorium on certain regulatory actions. During the moratorium period, the Secretary may not disapprove state Medicaid plans if such denial is premised on the fact that they violate the so-called "same methodology" or "single standard" rule.[3] As the Supreme

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amount paid to a family of the same size under a state's AFDC plan. But this exception applies only if a state's AFDC plan provides that some large families with different numbers of children get equal amounts. The panel renders this congressionally-approved exception a nullity, since under its holding the Secretary would have authority to reach the same result under (B)(i).

[3] The terms appear to be synonymous. Section 1396a(a)(10(C)(i) requires state plans to describe the criteria for membership in the vari-

Court recently explained in *Atkins* v. *Rivera*, 54 U.S.L.W. 4731, 4734 (June 24, 1986), the "same methodology" rule deals with the question of what resources are counted toward income in determining Medicaid eligibility. The statute provides that a state must use the "same methodology" in establishing an applicant's eligibility for Medicaid as it would if he were applying for other welfare programs, typically AFDC and SSI. That is, if a resource (such as interest) is counted toward establishing eligibility for AFDC or SSI, it must also be counted for purposes of Medicaid. 54 U.S.L.W. at 4733.

As the Supreme Court further explained, in 1981 the Secretary promulgated regulations that weakened the "same methodology" rule by permitting the States "to use eligibility standards that were unrelated to the standards used in AFDC or SSI, as long as the standards were 'reasonable.' " 54 U.S.L.W. at 4734 (footnote omitted). Congress disapproved this approach and in 1982 passed 42 U.S.C. § 1396a(10)(C)(i)(III) as part of the Tax Equity and Fiscal Responsibility Act (TEFRA) for the sole purpose of invalidating these regulations. 54 U.S.L.W. at 4734. Two years later, Congress had second thoughts and passed the DEFRA moratorium in order to block the operation of TEFRA for a period of 18 to 30 months. *Id.* at 4734 n.10. It is this latest chapter in the "same

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ous groups of medically needy individuals (e.g. the old, the blind, the disabled) and to describe

> the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under [e.g. AFDC or SSI].

The panel refers to this section as the "single standard" requirement, *see* 781 F.2d at 1429, while the Supreme Court refers to it as the "same methodology" requirement, *see* 54 U.S.L.W. at 4732.

methodology" controversy on which the panel relies as its alternative basis for striking down the Secretary's ruling.

As *Atkins* makes clear, however, the DEFRA moratorium, and the "same methodology" question it addresses, has nothing at all to do with this case. The "same methodology" requirement deals with what resources are counted in defining income. The question here is how much income (however defined) a family may have and still be considered medically needy.[4] The two provisions have about as much in common as apples and pineapples: They sound vaguely similar but they grow on entirely different statutory trees.

B.

In addition to fundamentally misreading the statute, the panel errs by applying DEFRA's moratorium to something that is not yet a state plan, only a proposed plan. DEFRA, by its terms, prohibits the Secretary from taking any regulatory action against a "State's [Medicaid] plan." Until approved by the Secretary, California's proposed amendment does not become part of its plan and therefore cannot benefit from the moratorium. This interpretation comports not only with the language of the statute but with common sense as well. Under the panel's interpretation, states may raise the MNIL as high as they want during the moratorium and force the federal government to contribute. So construed, DEFRA removes significant federal fiscal control over Medicaid participation, risking a hemorrhage of federal funding for this program.

---

[4] Whether alimony is considered for the purpose of establishing Medicaid eligibility is a "same methodology" question; whether the income exceeds the maxium a family of two or a family of three could receive under AFDC is not.

C.

Finally, I have considerable difficulty with the panel's contorting of the Secretary's decision in order to strike it down. The Secretary quite properly relied on section 1396b(f) in disapproving California's proposed plan, not on section 1396a(C)(i)(III), the subject of the DEFRA moratorium. In order to find fault with the Secretary's action, the panel tells the Secretary that he acted with motives he denies having and pursuant to statutory powers he denies exercising. Such psychoanalysis of administrative decision-making far exceeds the bounds of judicial review. If the Secretary properly bases his decision on a particular statutory provision, as he did here, it is irrelevant that he could (or could not) have based his decision on something else.

## CONCLUSION

In law, as in life, two wrongs add up to two wrongs, nothing more. Neither of the panel's chosen pathways lead to the result it reaches; they certainly cannot not do so in tandem. In reaching that result anyway, the opinion muddies the waters in two important areas of the law. I would take the case en banc, vacate the panel's opinion, affirm the Secretary's decision and set the law of the circuit back on course.

**APPENDIX F**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Certified Mail

Ralph M. Johnson, Esq.
Deputy Attorney General
350 McAllister Street
Room 6000
San Francisco, California 94102

Dear Mr. Johnson:

Re: *California State Plan Amendment No. 83-14,*
Docket No. 84-6

I have enclosed a copy of the Administrator's final decision regarding *California State Plan Amendment No. 83-14.*

By copy of this letter, I am transmitting to the other parties a copy of the final decision. This decision constitutes a "final determination" within the meaning of section 1116(a)(3) of the Social Security Act and 45 CFR 201.7, and "final agency action" within the meaning of 5 U.S.C. 704. If the State is dissatisfied with this determination, it may, within sixty (60) days after receipt of this decision, file with the United States Court of Appeals for the Ninth Circuit a petition for review.

Sincerely yours,

/s/ IRWIN COHEN
Irwin Cohen
*Attorney-Advisor*

Enclosure

cc:
Brenda Kohn, Esq.
Assistant Regional Attorney
50 United Nations Plaza
San Francisco, California 94102

Evelyn R. Frank, Esq.
Legal Aid Society of Alameda County
2357 San Pablo Avenue
Oakland, California 94612

DEPARTMENT OF HEALTH AND
HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Docket No. 84-6

IN THE MATTER OF:

CALIFORNIA
STATE PLAN AMENDMENT 83-14

**DECISION OF THE ADMINISTRATOR**

This case is before the Administrator, Health Care Financing Administration (HCFA), for final agency action under § 1116 of the Social Security Act, as amended [42 USC 1316]. The State of California, the Regional Attorney for HCFA, and the Legal Aid Society of Alameda County submitted exceptions to and comments on the Hearing Examiner's Recommended Decision. The time for submitting such exceptions has now expired. Accordingly this matter is ready for the Administrator's final decision pursuant to 45 CFR 213.32.

The entire record which was furnished by the Hearing Examiner has been carefully reviewed, including all the parties' briefs, exhibits, declarations, depositions, the transcript of the oral hearing, and the parties' post-hearing submissions. The Hearing Examiner's Recommended Decision has been considered by the Administrator. All correspondence and exceptions sent or received after entry of the Recommended Decision have been made a part of the record and all exceptions and related arguments were examined.

This matter concerns a request (February 16, 1984) by the State of California to the Associate Regional Admin-

istrator (Region IX) of HCFA. The request sought reconsideration of the Administrator's disapproval of State Plan Amendment 83-14 which proposed to increase the medically needy income level (MNIL) and to provide a separate MNIL for families of two adults. At issue in this matter is the Administrator's initial finding in which the Hearing Examiner concurred. These decisions held that the State's plan amendment could not be approved because the provision for an adult couple MNIL violated requirements placed upon state plans under Title XIX.

The Deputy Attorney General for the State of California submitted exceptions to the Hearing Examiner's Recommended Decision. These exceptions concerned a finding that the State had not relied on Regional Office Manual (ROM) § 2572, and they pointed out that the ROM had never been invalidated by regulations even though that was predicted by a HCFA policy official. The State contends that evidence in the record shows that HCFA employees knew before the California legislature acted that California planned to act in accordance with the ROM. Other evidence is cited by the State which is interpreted to reflect the reliance placed upon the ROM by the State's legislature. Because of this reliance, the State argues that the Recommended Decision is unsupported by the record.

The Department of Health and Human Services' Assistant Regional Attorney replied to the State's exceptions and commented that the evidence cited by the State is not credible to prove that the State did rely on the ROM. Citing other evidence and declarations, the DHHS attorney states that the one leading sponsor of the State's legislation, whose remarks were introduced into the record, did not even refer to the ROM as a reason behind the change. The Regional Attorney reasoned that evidence of awareness is not the same as proof of actual reliance.

These comments also make two additional observations, first—that even if the State had relied upon the ROM, HCFA never lead the State to do so; and second—that the Hearing examiner's finding concerning the State's reliance is not central to the controversy here, and such reliance would not invalidate the HCFA's determination.

The Legal Aid Society of Alameda County on behalf of Intervenors, affected adult couples in California, also submitted exceptions. The Society contends that the State relied on the ROM and cited the Commerce Clearing House, *Medicare and Medicaid Guide* and 42 CFR 201.3(c) to show that such reliance was appropriate. The cited regulation states that policy statements and precedent approved by the Administrator serve as the basis for action on state plans. The society concludes from this that the ROM was such a policy statement and was part of a body of substantive pronouncements upon which the State may rely.

The Society also considered the Hearing Examiner's finding that the 1984 Deficit Reduction Act supported HCFA's refusal to implement the ROM and that the moratorium enacted at DRA § 2373(c) did not apply. The exceptions charged that there is no evidence that when Congress rejected the House version (which adopted the ROM "interpretation of § 1903(f)" of the Societ Security Act), it supported HCFA's position. Instead, according to the Society, Congress made it clear that during the moratorium States could establish less restrictive adult couple MNILs without sanction. The Intervenors' attorney further argued that the "Recommended Decision" avoided the moratorium imposed on the agency under the DRA, and that to adopt the Hearing Examiner's opinion would flout the will of Congress.

Throughout these proceedings the Society has urged that the State be given an opportunity to submit a con-

forming plan amendment. In its exceptions, the Intervenors' counsel again urges that this opportunity be afforded prior to the application of sanctions. In excepting to the Hearing Examiner's opinion the Society observes that these proceedings are governed by 45 CFR 201.6 rather than § 201.4 as the "Recommended Decision" concludes. Accordingly, the proceedings would directly involve sanctions. Under either provision, the Society comments, sanctions may be forthcoming which should be stayed until the State has an opportunity to correct its plan.

The Administrator has carefully examined the exceptions by the State, by the Legal Aid Society on behalf of the Intervenors, and the comments in reply to the State submitted by the Assistant Regional Attorney. As a result of this analysis, the Administrator agrees with the Hearing Examiner's opinion and recommendation to affirm the disapproval of California's State Plan Amendment 83-14. Accordingly, the Recommended Decision is hereby adopted in all respects not inconsistent with this decision.

The proper and applicable income limitation with respect to a family of two adults, eligible for protection under the Medicaid program, is governed by § 1903(f) of the Social Security Act, as amended [42 USC 1396(b)[*sic*]]. Other than for its exceptions, the language of § 1903(f)(B)(i) is plain and unequivocal:

> "the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size . . . under the plan of the State approved under Part A of title IV of this Act."

The regulation implementing the statute is 42 CFR 435.1007. Subsection (a)(1) is fully as clear as the statute:

> "(1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily be made under the State's AFDC plan to a family of the same size without income and resources. If the State's AFDC plan specifies a maximum family size beyond which there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State's AFDC plan increases benefits for additional family members in families below the maximum size."

Regardless of the possible greater maintenance needs of a two-adult family as opposed to an AFDC family of two (one child, one adult), the statute provides for a single MNIL for a family of two. That limit is 133 ⅓% of the maximum payment ordinarily made under the State's AFDC plan to a family of the same size without income and resources. Despite confusion over the term "reasonably related" (Intervenor's Exhibit 4) the regulation is absolutely clear regarding a family of two.

Affected parties in this matter have argued that recent legislation has interpreted or changed the rule at § 1903(f). Specifically, § 1902(a)(10)(C)(i)(III) of the Social Security Act (SSA), as amended by the Tax Equity and Fiscal Responsibility Act of 1982, [42 USC 1396(a)[*sic*]], is seen to establish a "single standard rule." At § 137 of TEFRA, the law changed the SSA § 1902(a) to require state plans to include description of the single standard for determining income and resource eligibility for all groups. This posi-

tion is the foundation for the related argument that 1984 legislation provided a moratorium on sanctions applying the TEFRA provision. Under this theory, HCFA is barred from disapproving the State's plan amendment in this proceeding.

This analysis has been closely considered, however, the Administrator finds that the 1982 legislation did not change the impact of § 1903(f) of the SSA. The Act as it existed before 1982 provided for payments under but one qualifying MNIL in each State for a family of any particular size. TEFRA did not change this, although it has impact elsewhere. Therefore, the subsequent 1984 legislated moratorium on action under the TEFRA provision does not foreclose action based upon 1903(f) of SSA.

Even if the 1983 Deficit Reduction Act were interpreted to affect § 1903(f), the moratorium does not bar these proceedings. The language of DRA § 2373(c) is specific. The Secretary is prohibited from taking sanctions (such as compliance, disallowances, penalties of other regulatory action) against States during the specified moratorium period where the States' approved Medicaid plans contain less restrictive income or resource methodologies that would otherwise be prohibited under § 1902(a)(10)((C)(i)(III). The moratorium does not require prospective approval of new plan amendments which in any respect violate the Act under TEFRA at § 1902(a) or 1903(f). The DRA refers clearly to a "State's plan under title XIX of the Social Security Act being determined to be in violation . . ." This explicit category does not include proposed State plan amendments that have not been approved under title XIX of the Act.

Considerable attention in the pleadings and at the hearing focused upon a publication which appears as a section in the Regional Office Manual (ROM). The document addresses the legal area at issue in this controversy and purports to approve a separate MNIL for adult couples. The document is dated prior to June 1979, and refers to an

earlier policy information question (PIO[*sic*]). During that period, § 1903(f) of SSA and the related implementing provisions of the Act cited by the Hearing Examiner were in force. The ROM section is patently contrary to the statute and was, therefore, invalid from its origination.

The State's alleged reliance upon the invalid Manual provision is, accordingly, irrelevant to the controversy to be decided here. The State and the Intervenors have made much of the publication and communications about the Manual provision. However, actual reliance was never established and it appears from the "departmental analysis" of the State's legislation enacting the proposed amendment (Exhibit 6-2 and 6-03 to the Deposition at Intervenors' Exhibit 15) that the author advising legislators was aware of the low order of significance to be attached to the ROM section ("transmittal"). Nevertheless, even had there been actual reliance, any potential HCFA liability could not require statutory violations, since the Secretary is bound to follow the direction of Congress. Further, the nature of that liability is not at issue here.

Concerning the Intervenor's objection to sanctions imposed prior to the State's having an opportunity to amend, the Hearing Examiner held that the issue was not before him. These proceedings arise under 45 CFR 201.4 and specific procedures at § 213. While sanctions associated with compliance are specifically considered in the hearings discussed at § 201.6, only the approval or disapproval of a proposed state plan is at issue here. The difference in these hearings is obvious and it follows that sanctions will be placed only when the State is found to be out of compliance. Since a compliance question is not raised here, the substance of the Society's objection is not a part of this decision.

Because of its provisions for separate MNILs for adult couples, the California State Plan Amendment 83-14 is found to be in violation of the statutory provisions identified in the Hearing Examiner's "Recommended Decision." For this reason this proposed amendment is disappoved.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: Jan. 30, 1985

/s/ CAROLYN K. DAVIS, PH.D.,
Carolyne K. Davis, Ph.D.,
Administrator
Health Care Financing
Administration

## APPENDIX G

Section 1903(f) of the Social Security Act, 42 U.S.C. 1396b(f), provides in relevant part:

> **Limitation on Federal participation in medical assistance.**
>
> (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act [42 USC §§ 601 et seq.]
>
> (ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

* * * * *

Section 2373(c)(1) of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 provides:

> (1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan under title XIX of the Social Security Act being determined to be in viola-

tion of [42 U.S.C. 1396a(a)(10)(C)(i)(III)] of such Act on account of such plan's having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

* * * * *

Section 137(b)(8) of the Tax Equity and Fiscal Responsibility Act of 1982, 42 U.S.C. 1396a(a)(10)(C)(i)(III), provides:

**Contents.** A State plan for medical assistance must –

* * * * *

(10) provide –

* * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) [42 U.S.C. § 1396d(a)] who are not described in subparagraph (A), then –

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

42 C.F.R. 435.811 (1983) provides:

**Medically needy income standards: General requirements.**

To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a covered group;

(c) For FFP purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size (see § 435.1007); and

(d) Reasonable (see § 435.812).

* * * * *

42 C.F.R. 435.1007 (1983) provides:

**Medical needy.**

(a) FFP is available in expenditures for services provided to medically needy recipients whose annual income after deductions specified in § 436.831(a) and (c) and § 436.832 does not exceed the following amounts, rounded to the next higher multiple of $100;

(1) For couples and families of two or more, 133⅓ percent of the highest money payment that would ordinarily to be made under the State's AFDC plan to a family of the same size without income and resources. If the State's AFDC plan specifies a maximum family size beyond which there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State's AFDC plan increases benefits for additional family members in families below the maximum size.

(2) For individuals, 133⅓ percent of an amount reasonably related to the highest money payment which would ordinarily be made under the State's AFDC plan to a family of two without income and resources.

Section 14005.12 of the Cal. Welf. & Inst. Code (West Supp. 1986) provides, in relevant part, as follows:

**Income levels for maintenance**

(a) For the purposes of Sections 14005.4 * * * and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(b) In the case of a single individual, the amount of the income level for maintenance per month shall be 80 percent of the highest amount that would ordinarily be paid to a family of two persons, without any income or resources, under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(c) In the case of a family of two adults, the income level for maintenance per month shall be the highest amount that would ordinarily be paid to a family of three persons without income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

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